Filing at a Glance

Company:	The Union Labor Life Insurance Company
Product Name:	ULLGA-TL-0302 1211
State:	Arkansas
TOI:	L04G Group Life - Term
Sub-TOI:	L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
Filing Type:	Form
Date Submitted:	11/01/2012
SERFF Tr Num:	ULCC-128752200
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	ULLGA-TL-0302 1211
Implementation Date Requested:	On Approval
Author(s):	Kevin Ross, Carla Wallace
Reviewer(s):	Linda Bird (primary)
Disposition Date:	11/06/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *The Union Labor Life Insurance Company*
TOI/Sub-TOI: *L04G Group Life - Term/L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name: *ULLGA-TL-0302 1211*
Project Name/Number: *Group Term Life Insurance Application/*

General Information

Project Name: Group Term Life Insurance Application
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Filing Status Changed: 11/06/2012
State Status Changed: 11/06/2012
Created By: Carla Wallace
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type:
Overall Rate Impact:

Deemer Date:
Submitted By: Carla Wallace

Filing Description:

Re: New Group Life Insurance Application Form Filing
Group Life Insurance Application, ULLGA-TL-0302 1211

The Union Labor Life Insurance Company
NAIC 781-69744 FEIN 13-1423090

Dear Sir or Madam:

Please find enclosed for your review and approval the above reference Group Life Insurance Application filing, form ULLGA-TL-0302 1211. This application form was approved for use by the Department on December 27, 2011. Please refer to SERFF Tracking Number: ULCC-127891156.

The purpose of this filing is to revised the Medical Investigation Bureau (MIB) language to conform to the newly adopted MIB authorization language. No other changes have been made to this form as previosuly approved.

This application will be used in connection with our currently approved Group Term Life Insurance products:

- ULLG-10TL-0302 approved by the Department on August 15, 2002.
- ULLG-RTL-0308 approved by the Department on August 11, 2010.
- ULLG-T70-595 approved by the Department on October 8, 1996.

If you have questions, I can be reached at 202-962-2901 or cwallace@ullico.com. Please advise us of your decision at your earliest convenience.

Thank you,

Carla Wallace
Senior Compliance Analyst

Company and Contact

State: *Arkansas* ***Filing Company:*** *The Union Labor Life Insurance Company*
TOI/Sub-TOI: *L04G Group Life - Term/L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name: *ULLGA-TL-0302 1211*
Project Name/Number: *Group Term Life Insurance Application/*

Filing Contact Information

Carla Wallace, Compliance Analyst
8403 Colesville Rd
Silver Spring, MD 20910

cwallace@ullico.com
202-962-2901 [Phone]

Filing Company Information

The Union Labor Life Insurance Company
8403 Colesville Road
Silver Spring, MD 20910
(202) 682-0900 ext. [Phone]

CoCode: 69744
Group Code: 781
Group Name:
FEIN Number: 13-1423090

State of Domicile: Maryland
Company Type: Life and Heallth
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$125.00
Retaliatory?	Yes
Fee Explanation:	1 form @ $125.00 = $125.00
Per Company:	No

Company	Amount	Date Processed	Transaction #
The Union Labor Life Insurance Company	$125.00	11/01/2012	64470854

SERFF Tracking #:	*ULCC-128752200*	***State Tracking #:***		***Company Tracking #:***	*ULLGA-TL-0302 1211*

State:	*Arkansas*	***Filing Company:***	*The Union Labor Life Insurance Company*
TOI/Sub-TOI:	*L04G Group Life - Term/L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*		
Product Name:	*ULLGA-TL-0302 1211*		
Project Name/Number:	*Group Term Life Insurance Application/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/06/2012	11/06/2012

SERFF Tracking #:	*ULCC-128752200*	***State Tracking #:***		***Company Tracking #:***	*ULLGA-TL-0302 1211*

State:	*Arkansas*	***Filing Company:***	*The Union Labor Life Insurance Company*
TOI/Sub-TOI:	*L04G Group Life - Term/L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*		
Product Name:	*ULLGA-TL-0302 1211*		
Project Name/Number:	*Group Term Life Insurance Application/*		

Disposition

Disposition Date: 11/06/2012
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	VARIABLE MEMORANDUM		Yes
Supporting Document	Redlined and Highlighted Copy		Yes
Form	LIFE INSURANCE APPLICATION		Yes

SERFF Tracking #:	*ULCC-128752200*	***State Tracking #:***		***Company Tracking #:***	*ULLGA-TL-0302 1211*

State:	*Arkansas*	***Filing Company:***	*The Union Labor Life Insurance Company*
TOI/Sub-TOI:	*L04G Group Life - Term/L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*		
Product Name:	*ULLGA-TL-0302 1211*		
Project Name/Number:	*Group Term Life Insurance Application/*		

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		LIFE INSURANCE APPLICATION	ULLGA-TL-0302 1211	AEF	Initial		48.400	ULLGA-TL-0302-1211.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

LIFE INSURANCE APPLICATION
THE UNION LABOR LIFE INSURANCE COMPANY
[Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910
Executive Office: 1625 Eye Street, N.W., Washington, D.C 20006]

[John Q. Sample
Street Road
Second Address Line
Anytown, US 00000]

[Member of:
International Union Personalized]

1. Please tell us about yourself [and your spouse (if applying)]:

[Your Name _____
Address 1 _____
Address 2 _____
City, State, Zip _____]
Date of Birth
☐☐■☐☐■☐☐☐☐
MONTH DAY YEAR
☐Male ☐ Female

State of Birth: ☐☐

Phone ☐☐☐■☐☐☐■☐☐☐☐
AREA CODE

Best time to call: ☐ Morning ☐ Afternoon ☐ Evening

Social Security # ☐☐☐■☐☐■☐☐☐☐
Driver's License# _____ State of Issue ☐☐

E-Mail Address _____
If you share your e-mail address, you may receive periodic e-mails about money-saving benefits endorsed by your Union. You will always have the right to opt-out of receiving these e-mails.

[International Union Name _____ Local #_____]

[Currently employed? ☐Yes ☐No

Employer_____

Length of Employment_____

Occupation _____

Duties _____

Employer Address_____
(street, city, state, zip)

Personal Earned Income $_____

Household Income $ _____

Net Worth $_____]

[Spouse* Name _____
Address 1 _____
Address 2 _____
City, State, Zip _____
Date of Birth
☐☐■☐☐■☐☐☐☐
MONTH DAY YEAR
☐Male ☐ Female

State of Birth: ☐☐

Phone ☐☐☐■☐☐☐■☐☐☐☐
AREA CODE

Best time to call: ☐ Morning ☐ Afternoon ☐ Evening

Social Security # ☐☐☐■☐☐■☐☐☐☐
Driver's License# _____ State of Issue ☐☐

E-Mail Address _____
If you share your e-mail address, you may receive periodic e-mails about money-saving benefits endorsed by your Union. You will always have the right to opt-out of receiving these e-mails.

[International Union Name _____ Local #_____]

[Currently employed? ☐Yes ☐No

Employer_____

Length of Employment_____

Occupation _____

Duties _____

Employer Address_____
(street, city, state, zip)

Personal Earned Income $ _____

Household Income $_____

Net Worth $ _____]

[*Spouse includes Domestic Partner, Civil Union Partner, or Legal Partner as recognized by the jurisdiction in which you reside.]]

2. Please select the benefits you [and your spouse (if applying)] would like:

You:	[Spouse:
[Choose One Product and One Coverage Amount Below:]	[Choose One Product and One Coverage Amount Below:]
Product:	Product:
[☐ 10 Year Term ☐ 20 Year Term ☐ Other _____]	[☐ 10 Year Term ☐ 20 Year Term ☐ Other _____]
Coverage Amount:	Coverage Amount:
[☐$250,000 ☐ $200,000 ☐ $150,000 ☐ $100,000 ☐$75,000 ☐ $50,000 ☐ $25,000 ☐ Other _____]	[☐$250,000 ☐ $200,000 ☐ $150,000 ☐ $100,000 ☐$75,000 ☐ $50,000 ☐ $25,000 ☐ Other _____]
[Please check any additional coverage that you would like:	[Please check any additional coverage that you would like:
☐ Accidental Death Rider: Coverage Amount:	☐ Accidental Death Rider: Coverage Amount:
[☐$100,000 ☐ $75,000 ☐ $50,000 ☐ $25,000 ☐ Other ___]	[☐$100,000 ☐ $75,000 ☐ $50,000 ☐ $25,000 ☐ Other _____]
☐ Hospital Accident Rider: Coverage Amount:	☐ Hospital Accident Rider: Coverage Amount:
[☐$100 A Day ☐ $50 A Day] ☐ Other ___]	[☐$100 A Day ☐ $50 A Day] ☐ Other _____]
☐ Waiver of Premium Rider	☐ Waiver of Premium Rider
☐ Return of Premium Rider (20 Year Term only)	☐ Return of Premium Rider (20 Year Term only)
☐ Children's Term Life coverage: Coverage amount:	☐ Children's Term Life coverage: Coverage amount:
[☐$10,000 ☐ $5,000 ☐ Other _____]	[☐$10,000 ☐ $5,000 ☐ Other _____]
List name(s) and date(s) of birth in the section below:	List name(s) and date(s) of birth in the section below:
Name_____ Date of birth ☐☐☐☐	Name_____ Date of birth ☐☐☐☐
Name_____ Date of birth ☐☐☐☐	Name_____ Date of birth ☐☐☐☐
Use a separate sheet of paper if more space is needed.]	Use a separate sheet of paper if more space is needed.]]
Will this insurance replace or change any life insurance or annuity contract? [If yes, provide details below.] ☐ Yes ☐ No	[Will this insurance replace or change any life insurance or annuity contract? [If yes, provide details below.] ☐ Yes ☐ No
Please complete the beneficiary information:	Please complete the beneficiary information:
Your Beneficiary: _____Relationship_____	Your Beneficiary: _____Relationship_____
Address: _____	Address: _____
City, State, Zip:_____	City, State, Zip: _____
Social Security Number: ☐☐☐■☐☐■☐☐☐☐	Social Security Number: ☐☐☐■☐☐■☐☐☐☐]

[3. Please answer the following questions about you [and your spouse (if applying)]:

You: Height _____ FEET/INCHES Weight _____ LBS.	[Spouse: Height _____ FEET/INCHES Weight _____ LBS.]

	You	**[Spouse**
[1. Have you been cited for driving under the influence of alcohol or drugs in the past 12 months?	☐Yes ☐ No	☐Yes ☐ No
2. Have you had your driver's license suspended or revoked for any reason in the past 3 years?	☐Yes ☐ No	☐Yes ☐ No
3. Have you had a heart attack or stroke within the past 6 months, been diagnosed or treated for cancer (other than skin cancer) within the past 2 years, or ever tested positive for HIV (Human Immunodeficiency Virus) infection?	☐Yes ☐ No	☐Yes ☐ No
4. In the past 5 years, has a medical professional diagnosed you with, treated you for, or told you to seek treatment because of: disease or disorder of the heart (including high blood pressure), blood or circulatory system, lungs, liver, bowel or kidneys, diabetes, stroke or cancer, mental or nervous disorders, or told you to reduce or discontinue use of any drug or alcohol?	☐Yes ☐ No	☐Yes ☐ No
5. Other than those conditions covered above, has a medical professional diagnosed you with any chronic illnesses or conditions which require periodic medical care or may require future surgery?	☐Yes ☐ No	☐Yes ☐ No
6. Within the past six weeks, have you been prescribed or taken any prescription medications?]	☐Yes ☐ No	☐Yes ☐ No]]

[[7. Have you used any tobacco or nicotine based products in the past 12 months?]	☐ Yes ☐ No [☐ Yes ☐ No]

If you answered "Yes" to any of the above questions, please provide as much detail as possible in the space below. Identify the question number, and include diagnoses, dates, durations, names, addresses and phone numbers of all attending physicians and medical facilities. Attach a separate sheet if needed.

_____

_____

_____]

[4.] Read, Sign and Date below.

I understand and affirm by my signature below that, to the best of my knowledge and belief, the information in this entire application is true and complete. I understand that a separate Certificate will be issued to each applicant and that no insurance is in effect until I am issued my Certificate and my first premium is paid before my effective date and during my lifetime. I understand that if I fail to give true and complete answers on this application, benefits may be denied. If any condition affecting my insurability as stated in this application changes between my application date and my Certificate Effective Date, I understand that benefits may be denied during the first 2 years of coverage.

[To determine my insurability, or for claims purposes, I authorize any physician, medical practitioner, institution, VA Hospital, or other medically related facility, insurance company, the Medical Information Bureau (MIB), or any Consumer Reporting Agency to give any information about my physical or mental health to the Company or its reinsurers. This authorization or its photocopy is valid for 24 months from the application date and I or my beneficiary may request a copy. I may revoke this authorization at any time by submitting a written revocation request to the Company, but the revocation will not affect actions taken before receipt of the revocation or any legal right the Company has to contest my certificate or a claim under my certificate based on information obtained prior to the revocation. I have read the applicable fraud notice on this application and the Information Regarding the Medical Information Bureau Pre-Notice enclosed with this form as required by the Fair Credit Reporting Act.]

[**For Residents of California**: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For Residents of Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For Residents of District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For Residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Residents of Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[**For Residents of Pennsylvania**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For Residents of Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For residents all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits.]

[Information Practices Notice

To determine eligibility for coverage, the Company may supplement the information provided by you with information from other sources. Any information you give us regarding your insurability, and any information received from other sources, will be treated as strictly confidential. In some situations, and in compliance with applicable laws, the Company may disclose necessary items of information to third parties without your specific authorization. You have the right to be told about, and to copy, if you wish, items of personal information which appear in our files. You also have the right to seek correction of information you believe to be inaccurate. If you would like a more detailed explanation of our information practices and the circumstances under which we may use or disclose information, please submit a written request to the Company, to the attention of the Privacy Officer at the Executive Office address.]

[Information Regarding the Medical Information Bureau Pre-Notice

Information regarding your insurability will be treated as confidential. I authorize The Union Labor Life Insurance Company or its reinsurers to make a brief report of my protected health information to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its member. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Union Labor Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at http://www.mib.com.]

X _____	**[X** _____
Your Signature Date	Spouse Signature Date]
[Signed at _____	[Signed at _____
City, State]	City, State]

[Agent Certification

I certify that: (1) the application was obtained personally and in my presence; (2) all questions on the application were asked, and any information recorded by me on this application is true and accurate to the best of my knowledge; (3) to the best of my knowledge, this policy will ☐ will not ☐ replace or change any existing life insurance or annuity policy(ies); and (4) I have witnessed the signature(s) on this application.

Licensed Agent's Signature	Agent's Printed Name	Agent's Number

Telephone Number	E-mail Address

License #	State

Date

Mail Certificate To: ☐ Owner ☐ Agent]

SERFF Tracking #:	*ULCC-128752200*	***State Tracking #:***	***Company Tracking #:*** *ULLGA-TL-0302 1211*

State:	*Arkansas*	***Filing Company:***	*The Union Labor Life Insurance Company*
TOI/Sub-TOI:	*L04G Group Life - Term/L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*		
Product Name:	*ULLGA-TL-0302 1211*		
Project Name/Number:	*Group Term Life Insurance Application/*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:	Document Attached.		
Attachment(s):			
READABILITY CERTIFICATION.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	VARIABLE MEMORANDUM		
Comments:	Please find attached a variable memorandum.		
Attachment(s):			
VARIABLE MEMORANDUM.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Redlined and Highlighted Copy		
Comments:			
Attachment(s):			
ULLGA-TL-0302-1211 Redlined Highlighted Copy.pdf			

The Union Labor Life Insurance Company

("We, Us, Our, the Company")
Administrative Office: 8403 Colesville Road, Silver Spring, Maryland 20910
Executive Office: 1625 Eye Street N.W., Washington DC 20006

READABILITY CERTIFICATION

I certify that the form submitted with this filing achieved the following score using the Flesch Test Reading Score standards.

Form	Description	Score
ULLGA-TL-0302 1211	Life Insurance Application	48.4

Stephanie Whalen,
VP Life and Health Operations

December 7, 2011

THE UNION LABOR LIFE INSURANCE COMPANY
VARIABLE MEMORANDUM
Group Life Insurance Application ULLGA-TL-0302-1211

Variable data is bracketed. Variable data will never exclude or limit provisions required by the governing jurisdiction.

1. The current address of the company will be provided.

2. The bracketed "John Q Sample" information in the top left hand corner of the application will reflect the name, address, city and state of the principal insured, if known.

3. The bracketed "Member of International Union Personalized" information in the top right hand corner of the application will reflect the name of the principal insured's union, if known.

4. In section 1, the variables "Your Name", "Address 1", "Address 2", and "City, State, Zip" will be omitted if the principal insured's personal data is pre-populated in the "John Q Sample" information in the top left hand corner of the application as referenced in item 2. above.

5. If the variables in section 1,"Your Name", "Address 1", "Address 2", and "City, State, Zip" are included, they will reflect the proposed principal insured's actual personal data. In addition:

   a. the variable "International Union Name _____ Local#_____" will be included when the group policyholder is an International Union and this information is not pre-populated or known; and

   b. the variables regarding the proposed insured's employment may be used for agent sales and the financial information may be excluded or included for suitability purposes.

6. If the product being offered with this application does not provide coverage for a member's spouse, all spouse information throughout the application will be omitted, including the request for a spouse's signature in section 4.

7. If coverage is provided for a spouse, the spouse information in section 1 will be included and may vary as follows:

   a. the variables "Spouse Name", "Address 1", "Address 2", and "City, State, Zip" will reflect the spouse's actual personal data;

   b. the variable "International Union Name _____ Local#_____" will be included when the spouse may be part of an International Union;

   c. the variables regarding the spouse's employment may be used for agent sales and the financial information may be excluded or included for suitability purposes; and

   d. The clarification of the term "Spouse" is variable and may be changed to reflect state and/or federal requirements, if any or as required by our or the group policyholder's requirements. In no way will this variability be used to circumvent or violate state or federal law.

8. The benefits and amounts shown in section 2 of the application are illustrative, and will vary according to the benefits and amounts being offered. For example, if only one product or benefit amount is offered, the variable "Choose One Product and One Coverage Amount Below" will be deleted or revised to reflect the choices. Also, we may only offer the 10 Year Term benefit with available benefit amounts of $25,000, $50,000, and $75,000. In such case only that benefit and those available benefit amounts will be included. Similarly, we may only offer additional coverage for Accidental Death, in which case only the Accidental Death benefit option will be included.

9. The variable "If yes, provide details below" in the replacement or change of insurance coverage questions for both the proposed insured and the spouse, (if coverage is provided for a spouse,) will only be included as determined by us.

10. Section 3 will be deleted in its entirety if coverage is offered on a guaranteed issue basis without tobacco use distinct rates. If coverage is offered on a guaranteed issue basis with tobacco use distinct rates, only the tobacco/nicotine question 7 will appear. If underwriting is required, the height/weight section and questions 1 & 3 will always appear, as well as, any combination of the additional questions depending on the amount of underwriting.

11. Section designation "4" is variable and will be changed to section designation "3" if no medical questions are included.

12. The second paragraph in section 4 (or 3 if no medical questions are included on the application) will only be excluded if offered on a guaranteed issue basis.

13. Fraud language for the state where the offer is made will always be included. Inapplicable fraud statements (for example, for states not included in an offer) may be deleted.

14. The Information Practice Notice will not be used for a guaranteed issue basis.

15. The Information Regarding the Medical Information Bureau Pre-Notice will not be used for a guaranteed issued basis.

16. The variable "Signed at _____" will be included when we use this form with an agent.

17. The Agent Information will only be included when we use this form with an agent.

18. General – Type sizes may be increased to fill available space, but will never be less than 10 point. Section dividers may be colored instead of black, and may be reformatted. Some text may be in color instead of black. The form may be printed on paper other than white, but will NOT be printed with any ink/paper combination that would obscure any question or instruction.

LIFE INSURANCE APPLICATION
THE UNION LABOR LIFE INSURANCE COMPANY
[Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910
Executive Office: 1625 Eye Street, N.W., Washington, D.C 20006]

[John Q. Sample
Street Road
Second Address Line
Anytown, US 00000]

[Member of:
International Union Personalized]

1. Please tell us about yourself [and your spouse (if applying)]:

[Your Name _____
Address 1 _____
Address 2 _____
City, State, Zip _____]
Date of Birth
☐☐■☐☐■☐☐☐☐
MONTH DAY YEAR
☐Male ☐ Female

State of Birth: ☐☐

Phone ☐☐☐■☐☐☐■☐☐☐☐
AREA CODE

Best time to call: ☐ Morning ☐ Afternoon ☐ Evening

Social Security # ☐☐☐■☐☐■☐☐☐☐
Driver's License# _____ State of Issue ☐☐

E-Mail Address _____
If you share your e-mail address, you may receive periodic e-mails about money-saving benefits endorsed by your Union. You will always have the right to opt-out of receiving these e-mails.

[International Union Name _____ Local #_____]

[Currently employed? ☐Yes ☐No

Employer_____

Length of Employment_____

Occupation _____

Duties _____

Employer Address_____
(street, city, state, zip)

Personal Earned Income $_____

Household Income $ _____

Net Worth $_____]

[Spouse* Name _____
Address 1 _____
Address 2 _____
City, State, Zip _____
Date of Birth
☐☐■☐☐■☐☐☐☐
MONTH DAY YEAR
☐Male ☐ Female

State of Birth: ☐☐

Phone ☐☐☐■☐☐☐■☐☐☐☐
AREA CODE

Best time to call: ☐ Morning ☐ Afternoon ☐ Evening

Social Security # ☐☐☐■☐☐■☐☐☐☐
Driver's License# _____ State of Issue ☐☐

E-Mail Address _____
If you share your e-mail address, you may receive periodic e-mails about money-saving benefits endorsed by your Union. You will always have the right to opt-out of receiving these e-mails.

[International Union Name _____ Local #_____]

[Currently employed? ☐Yes ☐No

Employer_____

Length of Employment_____

Occupation _____

Duties _____

Employer Address_____
(street, city, state, zip)

Personal Earned Income $ _____

Household Income $_____

Net Worth $ _____]

[*Spouse includes Domestic Partner, Civil Union Partner, or Legal Partner as recognized by the jurisdiction in which you reside.]]

2. Please select the benefits you [and your spouse (if applying)] would like:

You:	[Spouse:
[Choose One Product and One Coverage Amount Below:]	[Choose One Product and One Coverage Amount Below:]
Product:	Product:
[☐ 10 Year Term ☐ 20 Year Term ☐ Other _____]	[☐ 10 Year Term ☐ 20 Year Term ☐ Other _____]
Coverage Amount:	Coverage Amount:
[☐$250,000 ☐ $200,000 ☐ $150,000 ☐ $100,000 ☐$75,000 ☐ $50,000 ☐ $25,000 ☐ Other _____]	[☐$250,000 ☐ $200,000 ☐ $150,000 ☐ $100,000 ☐$75,000 ☐ $50,000 ☐ $25,000 ☐ Other _____]
[Please check any additional coverage that you would like:	[Please check any additional coverage that you would like:
☐ Accidental Death Rider: Coverage Amount:	☐ Accidental Death Rider: Coverage Amount:
[☐$100,000 ☐ $75,000 ☐ $50,000 ☐ $25,000 ☐ Other ___]	[☐$100,000 ☐ $75,000 ☐ $50,000 ☐ $25,000 ☐ Other _____]
☐ Hospital Accident Rider: Coverage Amount:	☐ Hospital Accident Rider: Coverage Amount:
[☐$100 A Day ☐ $50 A Day] ☐ Other ___]	[☐$100 A Day ☐ $50 A Day] ☐ Other _____]
☐ Waiver of Premium Rider	☐ Waiver of Premium Rider
☐ Return of Premium Rider (20 Year Term only)	☐ Return of Premium Rider (20 Year Term only)
☐ Children's Term Life coverage: Coverage amount:	☐ Children's Term Life coverage: Coverage amount:
[☐$10,000 ☐ $5,000 ☐ Other _____]	[☐$10,000 ☐ $5,000 ☐ Other _____]
List name(s) and date(s) of birth in the section below:	List name(s) and date(s) of birth in the section below:
Name_____ Date of birth ☐☐☐☐	Name_____ Date of birth ☐☐☐☐
Name_____ Date of birth ☐☐☐☐	Name_____ Date of birth ☐☐☐☐
Use a separate sheet of paper if more space is needed.]	Use a separate sheet of paper if more space is needed.]]
Will this insurance replace or change any life insurance or annuity contract? [If yes, provide details below.] ☐ Yes ☐ No	[Will this insurance replace or change any life insurance or annuity contract? [If yes, provide details below.] ☐ Yes ☐ No
Please complete the beneficiary information:	Please complete the beneficiary information:
Your Beneficiary: _____Relationship_____	Your Beneficiary: _____Relationship_____
Address: _____	Address: _____
City, State, Zip:_____	City, State, Zip: _____
Social Security Number: ☐☐☐■☐☐■☐☐☐☐	Social Security Number: ☐☐☐■☐☐■☐☐☐☐]

[3. Please answer the following questions about you [and your spouse (if applying)]:

You: Height _____ FEET/INCHES Weight _____ LBS.	[Spouse: Height _____ FEET/INCHES Weight _____ LBS.]

	You	**[Spouse**
[1. Have you been cited for driving under the influence of alcohol or drugs in the past 12 months?	☐Yes ☐ No	☐Yes ☐ No
2. Have you had your driver's license suspended or revoked for any reason in the past 3 years?	☐Yes ☐ No	☐Yes ☐ No
3. Have you had a heart attack or stroke within the past 6 months, been diagnosed or treated for cancer (other than skin cancer) within the past 2 years, or ever tested positive for HIV (Human Immunodeficiency Virus) infection?	☐Yes ☐ No	☐Yes ☐ No
4. In the past 5 years, has a medical professional diagnosed you with, treated you for, or told you to seek treatment because of: disease or disorder of the heart (including high blood pressure), blood or circulatory system, lungs, liver, bowel or kidneys, diabetes, stroke or cancer, mental or nervous disorders, or told you to reduce or discontinue use of any drug or alcohol?	☐Yes ☐ No	☐Yes ☐ No
5. Other than those conditions covered above, has a medical professional diagnosed you with any chronic illnesses or conditions which require periodic medical care or may require future surgery?	☐Yes ☐ No	☐Yes ☐ No
6. Within the past six weeks, have you been prescribed or taken any prescription medications?]	☐Yes ☐ No	☐Yes ☐ No]]

[[7. Have you used any tobacco or nicotine based products in the past 12 months?]	☐ Yes ☐ No [☐ Yes ☐ No]

If you answered "Yes" to any of the above questions, please provide as much detail as possible in the space below. Identify the question number, and include diagnoses, dates, durations, names, addresses and phone numbers of all attending physicians and medical facilities. Attach a separate sheet if needed.

_____

_____

_____]

[4.] Read, Sign and Date below.

I understand and affirm by my signature below that, to the best of my knowledge and belief, the information in this entire application is true and complete. I understand that a separate Certificate will be issued to each applicant and that no insurance is in effect until I am issued my Certificate and my first premium is paid before my effective date and during my lifetime. I understand that if I fail to give true and complete answers on this application, benefits may be denied. If any condition affecting my insurability as stated in this application changes between my application date and my Certificate Effective Date, I understand that benefits may be denied during the first 2 years of coverage.

[To determine my insurability, or for claims purposes, I authorize any physician, medical practitioner, institution, VA Hospital, or other medically related facility, insurance company, the Medical Information Bureau (MIB), or any Consumer Reporting Agency to give any information about my physical or mental health to the Company or its reinsurers. This authorization or its photocopy is valid for 24 months from the application date and I or my beneficiary may request a copy. I may revoke this authorization at any time by submitting a written revocation request to the Company, but the revocation will not affect actions taken before receipt of the revocation or any legal right the Company has to contest my certificate or a claim under my certificate based on information obtained prior to the revocation. I have read the applicable fraud notice on this application and the Information Regarding the Medical Information Bureau Pre-Notice enclosed with this form as required by the Fair Credit Reporting Act.]

[**For Residents of California**: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For Residents of Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For Residents of District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For Residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Residents of Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[**For Residents of Pennsylvania**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For Residents of Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For residents all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits.]

[Information Practices Notice

To determine eligibility for coverage, the Company may supplement the information provided by you with information from other sources. Any information you give us regarding your insurability, and any information received from other sources, will be treated as strictly confidential. In some situations, and in compliance with applicable laws, the Company may disclose necessary items of information to third parties without your specific authorization. You have the right to be told about, and to copy, if you wish, items of personal information which appear in our files. You also have the right to seek correction of information you believe to be inaccurate. If you would like a more detailed explanation of our information practices and the circumstances under which we may use or disclose information, please submit a written request to the Company, to the attention of the Privacy Officer at the Executive Office address.]

[Information Regarding the Medical Information Bureau Pre-Notice

Information regarding your insurability will be treated as confidential. ~~The Union Labor Life Insurance Company or its reinsurers may; however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members.~~ I authorize The Union Labor Life Insurance Company or its reinsurers to make a brief report of my protected health information to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its member. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Union Labor Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at http://www.mib.com.]

X _____
Your Signature Date

[Signed at _____
City, State]

[X _____
Spouse Signature Date]

[Signed at _____
City, State]

[Agent Certification

I certify that: (1) the application was obtained personally and in my presence; (2) all questions on the application were asked, and any information recorded by me on this application is true and accurate to the best of my knowledge; (3) to the best of my knowledge, this policy will ☐ will not ☐ replace or change any existing life insurance or annuity policy(ies); and (4) I have witnessed the signature(s) on this application.

Licensed Agent's Signature	Agent's Printed Name	Agent's Number

Telephone Number	E-mail Address

License #	State

Date

Mail Certificate To: ☐ Owner ☐ Agent]